Facts About the Centers for Medicare & Medicaid Services

The Centers for Medicare & Medicaid Services (CMS) administers the Medicare program and works in partnership with the States to administer Medicaid, the State Children's Health Insurance Program (SCHIP), and health insurance portability standards. In addition to these programs, CMS has other responsibilities, including the administrative simplification standards from the Health Insurance Portability and Accountability Act of 1996 (HIPAA), quality standards in health care facilities through its survey and certification activity, and clinical laboratory quality standards.

About 83 million beneficiaries, or more than 1 in 4 Americans, receive health care coverage through Medicare, Medicaid, and SCHIP. Medicare covers almost 42 million people, and about 43 million are covered by Medicaid (including approximately 6 million who are dually eligible for Medicare and Medicaid). Additionally, more than 6 million children are covered by SCHIP through separate programs or Medicaid-based expansions.

CMS spends 20 percent of the Federal Government's dollars. In FY 2005, CMS will spend about $519 billion: 63 percent for Medicare, 35 percent for Medicaid and Medicaid administration, 1 percent for SCHIP, and 1 percent for other administrative costs. Including State spending, these programs spend about 45 percent of the Nation's health care dollars.

THE MEDICARE PROGRAM

Medicare is a social insurance program enacted in 1965 that is financed by a combination of payroll taxes from workers and their employers, beneficiary premium payments, and general Federal revenues. The program provides health insurance to people age 65 and over, those who have permanent kidney failure requiring dialysis or transplant, and certain individuals under 65 with disabilities.

THE MEDICARE MODERNIZATION ACT OF 2003

The recently enacted Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) made the most significant changes to the program since 1965. The law provides more choices in health care coverage and better health care benefits. MMA creates a discount drug card until a new Part D outpatient prescription drug benefit begins operation in 2006, allows for competition among health plans to foster innovation and flexibility in coverage, covers new preventive benefits, and makes numerous other changes. (For a more complete discussion, see the MMA page on the CMS Web site.)

In 2006, the new voluntary Part D outpatient prescription drug benefit will be available to beneficiaries from private drug plans as well as Medicare Advantage (mainly managed care) plans. Employers who provide retiree drug coverage will be eligible for a Federal subsidy. Beneficiaries with incomes less than 150 percent of the Federal poverty limit will be eligible for Medicare subsidies—a first for the program.

ORIGINAL MEDICARE

The fee-for-service Medicare program has two parts: Hospital Insurance (Part A) and Medical Insurance (Part B). Medicare Part A helps pay for inpatient hospital services, skilled nursing facility services, certain home health services, and hospice care. Medicare Part B helps pay for doctor services, outpatient hospital services, certain home health services, medical equipment and supplies, and other health services and supplies.

Since its inception, Medicare has contracted with insurance companies to administer the program. A Fiscal Intermediary is a private company that Medicare contracts with to pay hospitals, skilled nursing facilities, and home health agencies for their Part A and some Part B bills. A Carrier is a private company that Medicare contracts with to

pay physicians and other suppliers for their Part B bills. Under the contracting reform provisions of MMA, CMS will begin to contract for these services on a competitive basis.

Original Medicare is a fee-for-service payment model and is available everywhere in the United States. Beneficiaries are free to go to any doctor, specialist, or hospital that accepts Medicare, and most providers participate in Medicare. Beneficiaries and Medicare share the bill. More than 36 million beneficiaries are in original Medicare.

MEDICARE ADVANTAGE

MMA replaces the Medicare+Choice program with the Medicare Advantage program under Part C of Medicare. Under Medicare Advantage, beneficiaries can choose from an array of private health plan options, including HMOs, PPOs, and private fee-for-service plans (availability varies geographically). MMA changes how private plans will be paid in 2004 and thereafter. Private plans can use the enhanced payments provided under MMA to offer beneficiaries more generous coverage and to provide additional benefits that original Medicare may not.

In 2006, the following changes will be made to Medicare Advantage: new regional PPOs will be available to beneficiaries to increase private plan choices; Medicare and beneficiary payments to plans will be based on a new system of competitive bidding; and beneficiaries may choose to receive the new Part D prescription drug benefit from their Medicare Advantage plan. Nearly 5 million beneficiaries are enrolled in Medicare Advantage health plans.

THE MEDICAID PROGRAM

Medicaid eligibility is limited to individuals who fall into specified categories. The Federal statute identifies over 25 different eligibility categories for which Federal funds are available. These categories can be classified into broad coverage groups: pregnant women, children and teenagers, and individuals who are aged, blind, or disabled. The rules for counting income and resources vary from State to State and from group to group. For instance, there are special rules for those who live in nursing homes and for disabled children living at home. Generally, individuals who are poor, but who have no dependent children and are not disabled, may not qualify for Medicaid coverage no matter how low their income. Exceptions to this rule are some expansion populations in certain States with section 1115 waivers, which are meant to demonstrate a new or innovative approach for additions or improvements to the Medicaid program.

Medicaid was originally enacted in 1965 as a jointly funded program in which the Federal Government matches State spending to provide medical and health-related services. Although there are broad Federal requirements for Medicaid concerning eligibility, benefits, and provider payments, States have a wide degree of flexibility in designing their programs. The portion of the Medicaid program that is paid by the Federal Government is known as the Federal Medical Assistance Percentage. It is determined annually for each State by a formula that compares the State's average per capita income level with the national average (the Federal Government matches at least half of State spending).

States have the authority to establish eligibility standards, set the rate of payment for services, and determine the type, amount, duration, and scope of services. Because States have this flexibility, there are considerable variations from State to State.

The option to have a "medically needy" program allows States to extend Medicaid eligibility to additional qualified persons who may have too much income to qualify under the mandatory or optional categorically needy groups. This option allows them to spend down to Medicaid eligibility by incurring medical and/or remedial care expenses to offset their higher income. Many elderly in nursing homes eventually become eligible for Medicaid through this program.

States have sought waivers of Federal rules to expand health care coverage to low-income, uninsured populations and to test innovative approaches in health care service delivery. Although these demonstrations vary greatly, most employ a common overall approach: expanding the use of managed care for the Medicaid population. Nearly half of the States have comprehensive health care reform demonstrations.

MEDICAID-MEDICARE RELATIONSHIP

Medicare beneficiaries who have low income and limited resources may receive help paying for their Medicare premiums and out-of-pocket medical expenses through Medicaid. Various benefits are available to "dual eligibles," the more than 6 million Medicare beneficiaries eligible for some type of Medicaid benefit.

For persons who are eligible for full Medicaid coverage, the Medicaid program supplements Medicare coverage by providing services and supplies that are available under their State's Medicaid program. For services that are covered by both programs, Medicare pays first, and Medicaid pays for the beneficiary's cost sharing (up to the State's payment limit). Medicaid also covers additional services. For Medicare beneficiaries with incomes just above the Medicaid eligibility levels, limited Medicaid benefits are available to pay for out-of-pocket Medicare cost-sharing expenses and Medicare Part B premium for certain other Medicare beneficiaries.

THE STATE CHILDREN'S HEALTH INSURANCE PROGRAM

The Balanced Budget Act of 1997 created the State Children's Health Insurance Program (SCHIP), financed jointly by the Federal Government and the States. States may initiate and/or expand health insurance to uninsured, low-income children by designing a new children's health insurance program, expanding current Medicaid programs, or using a combination of both strategies. The program is the most significant improvement in access to health care for children since the creation of Medicaid; SCHIP covers more than 5 million children.

SCHIP is a capped entitlement for States. Congress appropriated $40 billion from FY 1998 through FY 2007 to help States expand health insurance to children whose families earn too much to qualify for Medicaid, yet not enough to afford private insurance. All States are participating in the program. CMS has worked in concert with many partners in the public and private sectors to encourage eligible families to sign up their children for coverage.

QUALITY IMPROVEMENT

In addition to providing health insurance through our programs, CMS performs a number of quality-focused activities that benefit all Americans. These activities include minimum quality standards through the survey and certification of health care facilities. State surveyors visit a certain number of facilities each year to determine compliance with CMS quality standards and investigate complaints from the public. CMS also regulates all laboratory testing (whether provided to beneficiaries of the programs or to others) under the Clinical Laboratory Improvement Amendments.

Under the Quality Improvement Organization program, CMS contracts with independent medical organizations to ensure that medical care paid under the Medicare program is reasonable and medically necessary, meets professionally recognized standards of health care, and is provided in the most economical setting. CMS is further working to improve the quality of health care by measuring and improving outcomes of care, educating health care providers about quality improvement opportunities, and educating beneficiaries to make good health care choices. CMS provides comparative quality information about nursing homes and home health agencies on our Web site. Comparative quality information for hospitals is under development.

THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)

Insurance Reform

The Department of Health and Human Services, the Department of Labor, and the Department of Treasury have roles in implementing the insurance reform provisions of HIPAA. CMS works with States to comply with the small group and individual market provisions of HIPAA. This part of the law is designed to protect health insurance coverage for workers and their families when they change or lose their jobs. For the first time, the Act applies the same rules governing portability of health insurance coverage across the large group, small group, and individual insurance

markets. It limits the application of preexisting condition clauses and imposes requirements concerning mental health parity.

Administrative Simplification

HIPAA also contains administrative simplification provisions, which are designed to create national standards for electronic health information transactions. CMS implements these provisions.

Program Integrity

The Health Care Fraud and Abuse Control Program was established by HIPAA to reduce the amount of fraud and abuse in CMS programs. In addition to CMS, the Office of the Inspector General in HHS and the Federal Bureau of Investigation receive funds to combat health care fraud and abuse.

CMS—FACTS ABOUT THE AGENCY

CMS's national headquarters is located in Baltimore, Maryland. The 10 regional offices work with the contractors who administer the Medicare program and work with the States to administer Medicaid, SCHIP, HIPAA, and survey and certification of health care providers. CMS works closely with the Social Security Administration (SSA) to provide information about Medicare to beneficiaries applying for, or currently receiving, retirement or disability benefits at local SSA district offices.